Credit Application Page Two

Please review, sign, and return the acknowledgment pages along with this application.

This application and the information contained herein is a request for the extension of credit for commercial business use only and applicant certifies that the firm he represents is doing business as a: (please check one)
Corporation ☑, Partnership ☐ or Sole Proprietorship ☐.

The applicant authorizes the above named creditor to obtain written or oral credit reports from any credit reporting agency. The applicant further authorizes any bank or commercial business with whom the applicant is doing or has done any business with to give any and all necessary information to the creditor which will assist creditor in the credit investigation. The applicant further authorizes the creditor to reinvestigate the applicants' credit status from time to time as the creditor deems necessary and should creditor upon such reinvestigation deem it necessary to limit or terminate the credit arrangement with applicant, said applicant shall be notified in writing as to any adverse action. Upon approval of this application for credit, said applicant will be notified in writing along with the creditor's terms of sale and should applicant at some future time deviate from the creditor's terms of sale, said creditor reserves the right to terminate future extension of credit with applicant.

Important

If credit is extended, I (we) agree to pay Creditor all debts incurred within creditor's terms of sale.
I (we) expressly waive all right of exemption under the constitution and laws of the State of Alabama and any other state, as to personal property and I (we) agree to pay all costs of collection or attempting to collect or secure any and all debts which I (we) now owe or which I (we) may in the future owe creditors for goods sold to me (us) or for services rendered including a reasonable attorney's fee on the unpaid debt so long as any of said indebtedness is due and unpaid, and I consent and agree to the jurisdiction of the laws of the State of Alabama governing the collection of any and all debts. I also agree to pay a FINANCE CHARGE OF 1.5% PERCENT PER MONTH/ANNUAL PERCENTAGE OF 18%) on any unpaid past due balance. Creditor is hereby authorized to deliver goods or perform services for the following at my (our) request and charge same to my (our) account and this shall continue until written notice to the contrary is given and accepted, which acceptance shall be evidenced by signature of creditor.

Applicant's Signature: Lloyd H. Dobbs, MD Title: Owner / CEO

Applicant's Signature: _____ Title: _____

Witness my (our) hand(s) this the ____ day of _____, _____

Witness: _____ Date: _____

Please forward a copy of your current physician state license and your current DEA registration. Failure to do so will delay shipping of any pending orders. Copies may be faxed.

This is a federal requirement.

State Physicians' License #: 045798 Exp. Date: 12/31/2003

DEA Form #: BG6984984 Exp. Date: 09-30-2004

Please note that we now offer electronic fund transfers with a 1% discount off your total order at the time of purchase. See attached sheet for further information.
Also, if you choose to use our e.f.t. system or pay by credit card, the name Bergen Brunswig will appear on your statement.
All of the above information is for file purposes only and will be held in strictest confidence.

For office use only:
Credit Limit: _____ Date Approved: _____ Approved By: _____

EXHIBIT "1"

ONCOLOGY SUPPLY

P.O. BOX 3001 • DOTHAN, AL 36302
Tel: (800) 633-7555 • Fax: (800) 248-8205

APPLICATION FOR NEW ACCOUNT

The following is an application for credit with ONCOLOGY SUPPLY COMPANY. Also known as creditor within the general provisions of this application.

1. Company Information

Tax ID Number	Firm or Corp. Name			
30-0072577	Oncology + Hematology Centers of Atlanta			
Street Address: 465 Winn Way Suite 231				
P.O. Box	City: Decatur	County: DeKalb	State: Georgia	Zip: 30030
Telephone Number	Fax Number	Year Established	Is business incorporated? Yes ☑ No ☐ If so, under laws of what state?	

Billing Address (if different from above): Same

City	State	Zip	Phone No	Fax No

Parent Company	Street Address		
P.O. Box	City	State	Zip

Full Names of Officers, Partners and/or Proprietors: Lloyd G. Geddes, Jr, MD — Title: Owner - CEO

Please indicate the estimated monthly purchases from Oncology Supply Company (This will help us to determine the credit amount)

Monthly Amount: $ 50,000 - 75000.00/mo.

Payment terms: _____

Does your firm use purchase order numbers? Yes ☑ No ☐

Is your business a member of a GPO? Yes ☑ No ☐

If so, which GPO? JON

2. Bank References

Bank Name	Account #	Contact
Sun Trust Bank, Atlanta	1000003062279	Daniel Nance.
Address	City: Atlanta	State: Georgia	Zip	Phone: (404) 728-1204

3. Credit References

Company Name	Contact			
Address	City	State	Zip	Phone
Company Name	Contact			
Address	City	State	Zip	Phone

State license & DEA permit required for all accounts

Please be advised: Ship to address must match address on your DEA certificate for contract identification.

Legal Name: Oncology + Hematology Centers of Atlanta

D.B.A: 3/1/02

Shipping address business type (please choose most applicable):

____Dialysis/Nephrology	✓ Oncology/Hematology
____Hospital	____Individual (Patient)
____Hospital Outpatient Clinic	____Surgery Center
____Wholesaler/Distributor	____Home Health Care

____Physician – Please provide specialty_____

____Other – Please specify_____

Sales tax information (please choose only one):

____Federal Government (provide exemption documentation)F
____State/Local Government (provide exemption certificate)G
____Not for Profit (provide exemption certificate or IRS Determination Letter)N
____Retailer (provide Resale Certificate)R
____Wholesaler (provide Resale Certificate)W
✓ Physician (provide resale certificate, if applicable)P
____Other For Profit Healthcare – Nontaxable (resale certificate, if applicable)H
____Other For Profit Healthcare – Taxable-Y
____All Others – Taxable-Y

OSC frequently uses e-mail to efficiently deliver important information to our accounts. Please enter a general e-mail address for your office that we should send general correspondence to (i.e. shipment notification, recall notices, backorder status, special offers, etc)

e-mail address:_____

Signed:_____ Title:_____

Print Name:_____ Date:_____

Telephone: 888-877-3430
Facsimile: 800-248-8205

ONCOLOGY SUPPLY

40192

P.O. Box 2001 • Dothan, AL 36302 • Ph: (800) 633-7555 • Fax: (800) 248-8205

PROPRIETOR GUARANTY

By signing this Application, I acknowledge that I have personally guaranteed the debts and obligations of my business and agree that I am personally obligated to perform all of the terms of, and make all payments to Oncology Supply Company required by, the credit application of which this agreement is part.

First Name	Initial	Last Name	Social Security Number
Lloyd	G.	Geddes	267-95-2069
Present Home Address			Home Phone Number
1325 Scott Blvd.			(404)296-2060
City	State		Zip
Decatur	Georgia		30030
Authorized Signature			Date
Lloyd G. Geddes			1/28/04

(If you wish to inquire upon multiple owners, you must have authorized access for each individual)

First Name	Initial	Last Name	Social Security Number
Present Home Address			Home Phone Number
City	State		Zip
Authorized Signature			Date